

No. 2
-1-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12075

State File No. _____

APR 9 1941
Registration District No. 184

Primary Registration District No. 200

Registrar's No. 561

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. John's
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8815 Tudor Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth Feldewerth
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 10
year 1941 hour 3:30 minute 7P M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Clem Feldewerth 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 4 1869
(Month) (Day) (Year)

that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death Natural causes Duration _____

8. AGE: Years Months Days If less than one day
71 11 6 _____ hr. _____ min.

Due to Chronic myocarditis and arterio sclerosis

9. Birthplace O'Fallon Mo
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Housemaid

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

Major findings: _____

MOTHER FATHER { 12. Name Martin Bushmeyer
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Theresa Koster
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

Of operations _____
Of autopsy Yes

16. (a) Informant Mrs. Eleanor Shelton
(b) Address 8815 Tudor, St. John's Mo

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof 3-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Place: burial or cremation St. Charles Rorromea

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director H. C. Dallmeyer & Sons
(b) Address St. Charles Mo.

(Specify type of place) _____
(a) Means of injury _____
23. Signature Louis Stapp Carner (M. D. or other) _____
Address Kirkwood, Mo. Date signed 3/13/41

19. (a) MAR 13 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed: *John C. Dallmeyer*
Licensed Embalmer No. *2457*
P. O. Address: *St Charles Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.